DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **2003-05**

2. STATE: **MS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.54

7. FEDERAL BUDGET IMPACT:
a. FFY **2003** $
b. FFY **2004** $

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.18-A, Page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.18-A, Page 1

10. SUBJECT OF AMENDMENT: **This State Plan Amendment deletes the copayment for non-emergency transportation services from the State Plan. A $2.00 per round trip copayment was listed on a previous amendment in error.**

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: **Rica Lewis-Payton**

14. TITLE: **Executive Director**

15. DATE SUBMITTED: **January 28, 2003**

16. RETURN TO:
Rica Lewis-Payton, Executive Director
Miss. Division of Medicaid
Attn: Rose Compere
239 North Lamar Street, Suite 801
Jackson, MS 39201-1399

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
January 29, 2003

18. DATE APPROVED:
February 27, 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Rhonda R. Correll

22. TITLE:
Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE X1X OF THE SOCIAL SECURITY ACT

State: MISSISSIPPI

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905 (a) (1) through (5) and (7) of the Act:

Service	Type Charge Deduct.	Coins.	Copay	Amount and Basis for Determination
Ambulance			X	$3.00 per trip
Dental Visits			X	$3.00 per visit
Durable Medical Equipment, orthotics, and prostheticss (excludes medical supplies)			X	Up to $3.00 per item (varies per State payment for each item)
Eyeglasses			X	$3.00 per pair
Home Health visits			X	$3.00 per visit
Hospital Inpatient Days			X	$10.00 per day up to one-half the hospital's first day per diem per admission.
Hospital Outpatient visits			X	$3.00 per hospital outpatient visit
Physician Visits: office, home, emergency room, ophthalmological			X	$3.00 per visit
Prescription drugs			X	$1.00 per generic prescription, including refills $3.00 per brand name prescription, including refills
Rural Health Clinic visits, FQHC visits, and MSDH clinic visits			X	$ 3.00 per visit

When the average or typical State payments for the above services are taken into consideration, all copayments are computed at a level to maximize the effectiveness without causing undue hardship on the recipients, assuring that they do not exceed the maximum permitted under 42 CFR 447.54

The basis for determining the charge of each co-payment for all services except in-patient hospital was the standard co-payment amount described in 42 CFR Section 447.55. The maximum co-payment amount in 42 CFR Section 447.54 was applied to the agency's average or typical payment for the particular service. For in-patient hospital services, the amount was calculated so as not to exceed one-half the first day's per diem for each hospital per admission.

Providers are required by the agency's provider agreements and policy manuals to assume the responsibility for collecting the co-payment amounts from those beneficiaries who are required to pay co-payments. Providers are required to make the determination as to whether or not a Medicaid beneficiary is able to pay required co-payment amounts Providers are prohibited by the agency's provider agreements and policy manuals from denying services to Medicaid beneficiaries because of inability to pay the co-payment, in compliance with 42 CFR Section 447.15.

Providers are prohibited by the agency's provider agreements and policy manuals from charging co-payment amounts for those services and beneficiaries found in 42 CFR Section 447.53(b). Beneficiaries are educated regarding co-payment amounts and regarding those services and beneficiaries that are exempt from co-payments. The agency's claims payment system contains an edit that prohibits the reduction of the co-payment amount from an excluded service or beneficiary category.